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# Shifting the gravity of spending?

Exploring methods for supporting public health commissioners in priority-setting to improve population health and address health inequalities.

**Report of the findings of a follow on study**

Funded by  
  
National Institute for  
Health Research

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***January 2017***

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# 1 Introduction

## 1.1 Background to the study

The study, funded by the National Institute for Health Research (NIHR) School for Public Health Research (SPHR), brings together a research team led from Durham University with support from Newcastle, Northumbria, Sheffield and Kent Universities. The team comprises people with complementary skills in policy analysis, commissioning for health and wellbeing, knowledge exchange and health economics. In addition, an external advisory group (EAG), reflecting knowledge from public health, academia, the NHS and local government was established to provide advice and support throughout the study. Further information on this study is available here: <https://www.dur.ac.uk/public.health/projects/shiftingthegravity/>

## 1.2 Aims and objectives

The whole study aims to develop support for local authority-based public health commissioners and other stakeholders in prioritising investment in health and addressing health inequalities, and in deciding on disinvestment. In addition, it seeks to understand the issues surrounding the decision-making process. The specific research questions addressed in the overall study are:

1. Which prioritisation tools do commissioners find useful for prioritising public health investment and why?
2. What are the enablers and barriers for decision-making related to prioritising investment in public health?
3. What difference does the use of specific decision-making support exert on spending within and across programmes with reference to improving health and addressing health inequalities?

To address these three research questions, the NIHR SPHR study proceeded in two parts – a main study conducted between November 2012 and August 2015 in two phases, and then a one year follow on study conducted between September 2015 and October 2016. The study was aimed at developing support for local government-based decision-makers and other stakeholders in prioritising investment/disinvestment decisions in public health. Three English local authorities were selected for the study which involved holding an introductory workshop in each site outlining a range of decision-support methods and economic approaches which the sites were encouraged to consider adopting in their prioritisation discussions. Interviews were held in two phases to explore the potential value and utility of the tools and to identify any enablers or, conversely, barriers to their uptake in practice. Following the first phase interviews, targeted prioritisation support was offered through health economic workshops held in each location. The principal goal of the targeted workshops was to practise using the selected tool(s) by prioritising interventions for a particular topic or across a specific budget chosen by participants. The second phase interviews were held to obtain feedback on the support offered and received, and the extent to which it was found to be useful or not.

Findings from the main study are reported in Marks et al (2015)<sup>1</sup> and Hunter et al (2016)<sup>2</sup>. Briefly, while most participants in the three sites were broadly familiar with, and had a general understanding of, the key principles underlying the tools and their adoption in practice, there were various constraints in their widespread adoption especially among elected members. There were marked differences on these matters evident between the three locations. A recurrent theme was the importance of context – organisational, political and relational – in shaping what happened in practice. While the issue of prioritisation in public health decision-making is firmly on the agendas of local authorities, a conclusion from the main study was that more attention is required concerning the purpose and value of adopting the tools and being clear about the types and/or level of decision-making where they might be useful.

In the second phase of the study, whose findings are available in a separate report, a further round of interviews was carried out that aimed to shed further light on interviewees' thinking around the issues surrounding priority-setting, considering also priority-setting tools and their practical adoption in public health prioritisation processes<sup>2</sup>. This round of interviews (involving three sites) and a national survey of Health and Wellbeing Board (HWB) members that was conducted raised a series of issues and points of discussion that guided the team in carrying out a one year follow-on study, for which funding from NIHR SPHR was secured from September 2015 to August 2016. Its principal focus was the enablers and barriers for decision-making relating to prioritising investment in public health.

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<sup>1</sup> Marks L, Hunter, D.J, Scalabrini S, Gray J, McCafferty S, Payne N, Peckham S, Salway, S. & Thokala, P. (2015). The return of public health to local government in England: changing the parameters of the public health prioritization debate? *Public Health* 129(9): 1194-1203. DOI: 10.1016/j.puhe.2015.07.028

<sup>2</sup> Hunter D.J, Marks L, Brown J, Scalabrini S, Salway S, Vale L, Gray J & Payne N. (2016). The potential value of priority-setting methods in public health investment decisions: qualitative findings from three English local authorities. *Critical Public Health* 26(5): 578-587. DOI:10.1080/09581596.2016.1164299

## 2 Methods

Ethics approval for the study as a whole was obtained from Durham University's School of Medicine, Pharmacy and Health Ethics Committee.

The components of the follow-on study reported here were face-to-face interviews, observation at priority-setting meetings and a consideration of documents presented by interviewees.

### 2.1 Sites and interviewees

An initial set of five potential sites and three back-up sites (in case any of the first choices was unavailable or unwilling to participate) was compiled using a mixture of sources: sites where representatives who completed the national survey of HWBs mentioned in 1.2 (available at: <https://www.dur.ac.uk/resources/public.health/Shiftingthegravityofspending-resultsofanationalsurvey.pdf>) had indicated a willingness for further involvement or had demonstrated the use of a particular prioritisation tool; the research group's personal knowledge; site involvement in related public health research projects. The intention was to carry out the research at four sites, excluding the three that had been the focus of the main study which preceded the follow-on study. It was decided to remove from consideration one of the initial five sites which had become involved in a separate and ongoing research project led by CPPH.

The Directors of Public Health (DsPH) at the four remaining sites were invited to participate themselves and to invite relevant colleagues to participate. These could be drawn from Public Health Consultants, locally elected members, other senior local authority (LA) officers, senior representatives from the NHS Clinical Commissioning Groups (CCGs) or representatives from the local independent consumer watchdog for health and social care, Healthwatch. These categories would not necessarily be mutually exclusive, as some roles could include, for example, both health and social care.

At all four sites, there were preliminary telephone discussions with DsPH; at one site there was also a preliminary face-to-face discussion with the DPH; at another there were preliminary face-to-face discussions with the DPH and two other senior public health professionals. There were changes of DPH in two sites between the preliminary discussions and the formal discussions. The preliminary telephone and face-to-face discussions were not recorded but extensive notes were taken and findings from them are included as appropriate. One site had to withdraw at a late stage because of major unforeseen issues arising at the local authority. Changes among senior personnel had already affected the study's timescales for two of the other sites so it was decided not to look for a replacement site but to use only three sites for the formal interview stage.

Formal interviews were carried out in each of the three sites with the DPH (acting or substantive) and a public health consultant and an elected member with a role in public health, invited by the DPH. The interview schedule used in the more formal interviews (i.e. not in the preliminary discussions) is shown in Appendix 1.

Overall, between December 2015 and August 2016, there were discussions and/or more formal interviews with five people from one site, three from another, four from another and one from a site where subsequent unexpected and unforeseen developments occurred which meant that planned involvement in that site was less than had been anticipated. No further research activity took place in this particular LA.

## 2.2 Priority-setting meetings and documentation

The researcher was given permission to observe a series of priority-setting meetings at one site, the only one where such meetings were to take place within the research period. Related documentation (including submissions from activity leads for each of their chosen priorities) was provided. Sites also provided previous health and well-being strategies or business plans as background for the interviewer and score sheets or descriptions of their decision-making processes, where available (as described in section 3.)

## 2.3 Analysis

The site-based interviews for two sites were recorded and transcribed verbatim by an external transcription company. Failure of recording equipment meant that the third site interviews were not so recorded but the researcher, taking copious notes, asked for clarification or repetition as necessary throughout the interview. Analysis of interviews, meetings observed and documentation provided was carried out using thematic analysis.

## 2.4 Limitations of the research

Working with only three LAs out of 152 (with some input from the fourth which dropped out) means that the study sites included in the follow on phase are not representative of all local government organisations in England. In our defence, since all LAs are different, arguably no sample would have captured the full range of variation. Three other case study sites were the focus of the main study. Furthermore, and of greater importance, we were only interested in sites where there were developments underway with regard to prioritisation so that we could capture the issues encountered.

The research was concerned with interviewees' thinking around prioritisation approaches at a time when the public health function had only been fully incorporated into local authorities for two to three years. It therefore presents a snapshot at a unique time following the reorganisation of the public health function. Local authorities were developing their own individual approaches to both integrating the public health function and to setting their priorities for their new responsibilities.

Although it is unlikely that the findings are fully replicable or representative of all local authorities, several common issues were raised by many interviewees – issues also emerging in the national survey of selected members of HWBs mentioned above.



### 3 Findings 1: approach to prioritisation

#### 3.1 Site A: a scorecard approach limited to the public health budget

Site A had been using a matrix system in which a public health panel deliberates and allocates scores to a series of potential priority services against a set of parameters (including such items as value for money and effect on inequalities). The framework was adapted from *Maxwell's Dimensions of Quality*<sup>3</sup>. Scores were weighted, with different maximum values available for each parameter score. Table 1 shows the criteria, their definitions and the maximum scores available for each. Guidance to the scoring is shown in Appendix 2.

Table 1: Site A criteria definitions and maximum scores

Criterion	Definition	Maximum score
Public Health Impact	Does the intervention directly impact on the Public Health Outcomes Framework indicators?	40
Access	What is the number of residents who are expected to directly benefit from this intervention per year?	20
Vulnerable communities	How does this address the direct needs of vulnerable communities/population groups?	40
Evidence of effectiveness	What is the strength of evidence of effect of the intervention and its impact?	40
Efficiency/value for money	How does this intervention provide value for money and what is the spend per head?	40
Acceptability/sustainability	What would the local impact amongst wider stakeholders or the public be if a reduction or removal of service occurred, e.g. health partners, voluntary sector, etc.?	20

The forms also included another section with three questions:

- Would be possible for another organisation to fund the service?
  - Possible answers: 'fully', 'partially', 'no'. If answer was 'fully' or 'partially', a further question was asked - 'Which organisation could do this?'
- If this service takes a population approach, would it be possible to alter this to a targeted approach?
  - Possible answers: 'yes' or 'no'. If answer was 'no', a further question was asked - 'why?'
- What does the Spend and Outcome Tool (SPOT)<sup>4</sup> for local authorities highlight in terms of Spend vs Outcomes?

This approach, although felt to be quite robust, had developed initially with only senior public health member of staff on the panel, mainly because there was felt to be still a

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<sup>3</sup> Maxwell R.J. Dimensions of Quality Revisited: from thought to action. *Quality in Health Care* 1992;1:171-177

<sup>4</sup> Spend and Outcome Tool, which allows organisations to gain an overview of spend and outcomes across all programmes of care and to compare themselves with other organisations

culture of silo-working across the council and the DPH wished to retain control of the ring-fenced budget.

The researcher was allowed to sit in on a series of priority-setting meetings using this approach. In each, the proposer or supporter of a potential priority (usually the service lead or main public health contact for that service, who was then available for discussion with the panel) had previously completed the text relating to each criterion, including a brief service description and any evidence of effect. The panel then discussed the application and agreed points for each criterion, calling in the service lead for clarification if necessary. There was a high degree of consensus among panel members in almost every case. There was no evidence of any tendency to allocate average scores, which can happen when panels are aiming for consensus. Instead, rational discussion around any points of initial minor disagreement led to joint understanding and agreement, with a wide range of scores allocated to different proposals. The researcher questioned whether there might ever have to be a 'casting vote' and was told that although theoretically this would be the decision of the DPH, a casting vote had not had to be invoked at all.

The priority-setting meetings were arranged in such a way that related topics were covered on the same day. This meant that where there might be overlap of services, the panel could compare the respective scores and potentially identify and eradicate duplication. The researcher also witnessed instances where a panel member considering one return wondered whether an earlier return had been scored differently. This led to a reconsideration of the earlier considered form so that consistency was assured.

Between the first site visit, when the researcher observed the priority-setting meetings, and the second site visit, when the researcher carried out the more formal interviews, the prioritisation matrix had been amended to give more weight to preventive measures and to include something on evaluation, deemed essential for sustainability. Financial consideration was changed to reflect future spend not current spend. Additionally, the panel was no longer restricted to senior public health professionals but now included financial professionals and other key council and CCG externals (slightly different in each of four panels and chosen from JSNA group members). This was felt by one interviewee to have added value to the process, allowing challenges to be raised and resolved and increasing the level of support for decisions.

### 3.2 Site B: cuts lead to abandonment of formalised prioritisation approaches

Even in the short space of time between the start of the follow-on study and the interviews, the approach taken by this site had to change, to reflect the overall council requirements following substantial budget cuts. A previously used approach to public health budget prioritisation (reportedly successful, according to interviews who commented on it) had involved a system that helped people to prioritise by making them consider several questions about the impact of proposed actions. The approach had involved the development of a set of criteria, based on the wider determinants of health and the preventive agenda, considering how an activity could be justified to Public Health England

and how its outcomes could be mapped to the Public Health Outcomes Framework and to certain local strategies. Financial costs were only considered in the very last stage of assessment. Table 2 shows an initial version of the scoring, which was then later revised to the version shown in

Table 3, which included a weighting, about which more detail is provided in Appendix 3 .

*Table 2: Site B – initial prioritisation scoring*

Criterion	Item	Score
Population impact	Ward level	1
	Medium Super Output area (5000-15000)	2
	Borough wide	3
Identified need (e.g. links to Strategic Needs Assessment)	Large	5
	Significant	4
	Moderate	3
	Limited	2
	None	1
Inequalities impact (e.g. narrows the gap)	High impact	5
	Significant impact	4
	Modest impact	3
	Minimal impact	2
	No impact	1
Return on investment	Significant return on investment	5
	Substantial return on investment	4
	Medium return on investment	3
	Some return on investment	2
	No return on investment	1
Contribution to council sustainability strategy	Hits all key priorities	5
	Hits most key priorities	4
	Hits some key priorities	3
	Little contribution to key priorities	2
	No contribution to existing priorities	1
Delivers targets within council Performance Management Framework	Significant impact upon delivery	5
	Substantial impact upon delivery	4
	Moderate impact upon delivery	3
	Some impact upon delivery	2
	No impact upon delivery	1
Medium Term Financial Plan delivery risk	Significant and difficult risk	-5
	Substantial risk	-4
	Medium level of risk	-3
	Some risk	-2
	Minimal risk	-1
Evidence base for delivery	Significant and robust	5
	Substantial	4
	Medium	3
	Weak	2
	No clear evidence base	1

Table 3: Site B revised prioritisation scoring approach

Criterion	Definition	Weight
Narrowing the Gap	Does this service contribute to narrowing inequalities?	30
Feasibility of Delivery of Medium Term Financial Plan	Does this contribute to the delivery of MTFP within MTFP period with clear action plan/Service Level Agreement? (based on resources realised in MTFP period)	0
Link to Public Health needs	Clear links to public health population need demonstrated in Strategic Needs Assessment	30
Links to Frameworks	Clear links to Public Health Outcomes Framework (PHOF) indicator/Appendix C of grant conditions/Public Health Performance Management Framework	25
Evidence Base	Is there a sound evidence base for this delivery, e.g. NICE?	15

Events and changes led to this prioritisation matrix being redundant, as the council decided that only statutory responsibilities were to be funded.

### 3.3 Site C: Public health principles considered in light of local authority criteria

Site C did not use a formal or matrix approach for public health budget prioritisation but tried, not always successfully, to base its prioritisation discussions for its business plan on public health principles (being needs based, evidence based and being evaluated). The strategic triangle approach favoured by the council was then applied (seeing whether three criteria were satisfied: public value; authoritative environment (acceptance of politicians); and availability of resources). Only public health staff were involved in the discussions; the DPH said that this was because public health had so little choice about much of its spending that they did not want to give others the chance to spend what little it still had of the diminishing funds.

### 3.4 Site D

Site D developed its priorities through discussions, maintaining a focus on the preventive agenda rather than services and aiming to align public health expenditure on delivering outcomes across the whole organization. (Planned involvement in this site was less than had been anticipated because of unrelated council problems – so no further detail or documentation is available but we decided to include it in our sample of sites since we were able to obtain relevant information and useful insights to illuminate our particular interests and permission was granted to use any data gathered.)

## 4 Findings 2: factors influencing decision-making related to prioritising investment in public health and how to address them

In this section, we consider factors that affect priority decision-making. We have not separated them into enablers and barriers because most of them can act as either.

### 4.1 Politics

A key influence was said to be the overall agenda of the council [DPH]. Key public health priorities such as sustainable communities and health inequalities were said by one councillor to have been huge issues that have shaped council decisions for many years but now needed to be addressed in a different way, perhaps with greater input from voluntary organizations. Interviewees at one site said that activities or initiatives were felt to be more likely to be supported when they clearly enhanced or supported statutory functions.

Where budgets are particularly squeezed, for example in a small local authority, focus will necessarily be on statutory responsibilities. Very few items related to public health are mandatory under the Health and Social Care Act (relating to: sexual health services (STI testing/treatment and contraception); NHS health checks; national child measurement programme, provision of public health advice to NHS commissioners; local authority role in health protection; health of 0-5 year olds). The mandatory responsibilities might also change over time. Several interviewees (at different sites) commented that as well as being vague ('woolly') in the extent to which the mandatory activities should be carried out, the list comprises mainly activities related to treatment, rather than to prevention.

There can be barriers erected by individual councillors, fighting for their own wards, as well as by an overall council agenda. The example was given by a DPH of one councillor who was generally very supportive of preventive public health work but would not allow the diversion of spending from their own ward. The timing of elections can also delay or affect decision-making. A public health consultant described it in these terms:

*There are still circumstances where, if we suggested 'disinvest in something', then that's where the political element would come into it. So if, for example, there's an election coming up, there would be a sort of 'hold off until after the election' because they don't want to announce it beforehand.*

Another potential issue around individual members was raised at one site. It had been found that when a lifestyle behaviour change was involved, councillors who smoked might not support some actions because if they were then seen in public smoking, they would be regarded as hypocrites and their image damaged. The case was similar for action on alcohol or on obesity (one public health consultant facetiously suggested that eating chocolate in public might become difficult for a councillor).

Although two of the sites said that Cabinet had the final say, at one site all interviewees reported that the leader of the council, rather than cabinet, was the one with the power to make decisions. The leader's main focus was the economy and jobs, and priorities that did not contribute to this tended to be rejected.

In terms of addressing barriers formed by politics, it was suggested by a DPH that the role of the public health director and department needs to be partly one of helping people to understand what public health is and what it does. One of the difficulties is in communicating across the council and its partners the value and level of support public health can provide, for instance in work on licensing, planning, environmental health and adults' and children's services. One public health department felt it had been very successful in work around the authority's licensing policy. The messages about public health contributions have to be conveyed without raising expectations too much, given the lack of capacity. As one DPH said

*I don't want to promise the world and deliver very little.*

The requirements of national political decisions might also affect the priorities that can be adopted. This can be particularly difficult when the national ruling party is not the same as the local ruling party. One site found that its public health priorities were shared by its local administration, which increased the level of support for them.

Silo working within the council was felt to be a real barrier to good prioritisation, with one site saying it would be really beneficial to public health if there could be true cross directorate and cross-agency shared prioritisation and shared budgeting.

## 4.2 Working relationships

### 4.2.1 Across the local authority

Although interviewees in all four sites reflected a view that public health had very good relationships with the rest of the local authority, it was recognised by interviewees that such relationships had taken a while to forge, starting some years before the transfer of responsibilities occurred. At one site, it was more difficult to judge the success of relationships. With some other departments, there were felt to be very good relationships, with public health having the opportunity to influence the business plans of those departments and ensure that public health and some other business plans were aligned. However, there were certainly – at the very least – communication issues between public health and the councillor with the health portfolio, as mentioned earlier, and it was also suggested by the public health professionals there that the local authority had failed to embrace its public health responsibilities.

The way the public health department fits into the administrative or management structure of a local authority can affect its ability to influence the council. For example, where it comes under adult services, extra effort might be needed to work on the children's health agenda.

One DPH commented that they were unsure whether other people understood inequalities in the same way as public health, with the difference between 'equal access' and 'equitable access' being a case in point. However, the public health consultant at the same site thought that now at least there were shared values about what is prevention; much work had been done to promote this, including sessions at relevant board meetings. Another area of

potential lack of understanding was the public health ring-fenced budget. Interviewees at more than one site commented on the way the rest of the council might not understand how and why public health should have a specific large pot of money (to be spent by a comparatively small department and possibly not being subject to budget cuts in the way other department budgets were).

Historically, local authorities had different ways of working from the former Primary Care Trusts (PCTs) which had led on public health that might need reconciling. One DPH said that in the PCT, public health would say 'this is the problem, this is what the evidence tells us, this is what we need to do about it'; however, the local authorities would prefer examples, case studies instead of public health's traditional 'evidence base' and so public health would need to strengthen its advocacy role.

*If we say this is an evidence-based approach, it leaves them cold, completely leaves them cold. So the less we use that phrase, the better and the more story-telling we do, so giving them examples and case studies of Mrs A going to this and this being the impact on their life, that's what they love.*

Historical ways of working also include adherence to particular processes. One public health professional, used to being able to represent the PCT at meetings to talk about public health issues, was taken to task for not checking with exactly the right people at the council before talking to a group interested in a particular health issue. Potential legal ramifications were apparently the reason. The interviewee felt that getting used to a new working environment (council etiquette and formal processes) is part of the adaptation process following the transfer of responsibilities.

Linked with historical ways of working is a difference in culture between PCTs and LAs. One site felt that there were cultural barriers; interviewees there felt there was more sharing of performance information in the NHS, with benchmarking commonly used, whereas in the LA, accustomed to being more independent, benchmarking was not well received, although this seemed to be changing. One interviewee said that public health and local authority were coming at it from different angles, with public health having to drop or modify its values. One councillor suggested that local authorities did not yet have the skills for commissioning.

Building on existing local authority practice can help public health to get its messages across. At one site, strong system-wide collaboration had been built on the back of the planning and health agenda, following the way the PCTs used to comment on major developments from the point of view of their impact on health.

The public health role is also increasingly becoming one of negotiation and influencing. Several interviewees (at different sites) stressed that it was members of the council, rather than officers, who had the decision-making power; it was therefore essential to ensure that the councillor with the relevant responsibility was kept very much informed about and engaged in key public health challenges. One councillor with that responsibility, who said that other departments were receptive to public health input, stressed the importance of raising awareness across the council and trying to embed public health into all departments,

also promoting public health to the media. This councillor also said that it was rare for their recommendations to be turned down by the Cabinet or Council. At one site, the DPH reported that the councillors were 'very supportive'. At another, there appeared to be a difference of opinion between the public health professionals and the responsible councillor as to the involvement of the latter; the councillor did not feel much involved and wished for much greater involvement, saying they did not know or understand the way the public health grant had been deployed; on the other hand, the public health professionals said the councillor was indeed kept informed (involving 'numerous discussions' about the expenditure) and had in fact helped to guide the department in whether something was a council priority.

Three of the four sites felt that the recommendations they put forward concerning public health expenditure were not often likely to be rejected. One site had also worked well to agree investment in prevention measures to support the HWB and the priorities of the health and wellbeing strategy. Another site, where the council leader was the final decision-maker as mentioned above, said that some of its suggested priorities would be knocked back by the member with the responsibility for the health agenda but even when that person was in agreement, the council leader would often overrule in Cabinet. Here, it was also challenging to be a public health advocate, as efforts would be challenged and the individual or the department would be reminded that they were now officers of the council. With regard to this latter point, the DPH annual report was felt to be vital, as it was mandatory but independent and was possibly the only way of getting across the real messages about health.

#### 4.2.2 NHS bodies

As one DPH pointed out, because of the statutory responsibility to support CCGs with public health advice and information,

*it's not just a good thing, it's a duty that we have to have a relationship that's effective and working well.*

The relationships of public health with the CCGs can, however, cause problems. One site reported that the CCG had felt that it had lost public health but was keen to retain its access to public health support. The site said it used a very interactive approach to maintain the relationship, ensuring that priorities were reassessed every year. One councillor pointed out that links with the CCG tended to be around services whilst links with other organizations were more around the preventive agenda. The same councillor reported that the CCG had described changes around integrated care as a backward step and had pulled out of two years' worth of work towards integration. One site had been deliberately trying to help its CCG colleagues to understand the preventive agenda, helped by the express wishes of Simon Stevens (Chief Executive of NHS England) concerning NHS sustainability and the need to increase preventive action. One DPH felt that although working with the NHS through the Local Development Plan created good opportunities for public health, it could also present challenges, for instance with the NHS finding it too easy to blame individual lifestyle choices rather than focusing on the environmental or wider determinants.



At one site it was felt that there had been particularly successful working with the CCG and voluntary sector over the social prescribing agenda. One site reported a very good relationship with the CCG, due in part to the relationship formed before the transfer of responsibilities. There was, however, a real concern that this relationship could be badly damaged by any future reorganizations.

One site reported having a good relationship with some very visionary GPs, who were fully engaged and working very hard but not yet fully aware of the preventive agenda.

There was little mention of the relationship between public health and the acute sector, although interviewees at one site said they were on very good terms and had worked well together over some issues (although it was recognized that conflicts can arise because payment mechanisms mean that acute trusts are incentivised to increase patient numbers).

The fundamental difference in overall organization of health sector bodies and local authorities was regarded as a big problem. CCGs have to do what NHS England or the Secretary of State decrees but councils do what their elected members choose to do (within their statutory responsibilities).

#### 4.2.3 Third sector and private sector

Another key relationship is that of the local authorities with the third sector. One councillor felt that their authority had a very mixed relationship with the voluntary sector. This was influenced partly by the local geography; third sector resources could be limited in small towns that could not support more than one or two of the large voluntary organizations already there. However, the statutory and voluntary sector had been working closely together, making use of umbrella organizations; an example was given of mental health activity, led by the health sector but provided by the voluntary sector.

The private sector also has a part to play. One authority was said to be increasing its use of private sector provision, particularly in mental health. Interviewees at another site commented on the good support from the energy industries in connection with work on fuel poverty.

#### 4.2.4 All organizations and sectors

Interviewees generally recognized the need for multi-sectoral, multi-agency working and gave examples, such as addressing air pollution, which needed the involvement of not only all the public sector agencies but also, in a very big way, the private sector. A desire for a system-wide approach, with health in all policies, was expressed by many interviewees (across all sites, health professionals and councillors alike).

The site where there were more difficulties with relationships within the LA (and the powerful council leader) reported that it was much easier for public health to have a good advisory role in boards which were not solely local authority boards, for example the Health and Wellbeing Board (HWB), where relationships with other partners were good (and public health was not regarded as a 'thorn in the side'). HWBs are statutory boards of the local authority and involve a range of partners.

One potential factor affecting all organizational relationships was said by one councillor to be the uncertainty engendered by ongoing reorganizations, which might lead to service changes and reduce confidence in partnership working. This could be even more significant in counties with two tier administrative systems (county-wide and smaller district local authorities, where services can be offered at both levels).

Geographical boundaries for services (for example where some people can receive a service but others just over a boundary cannot) can also affect perceptions about priorities and expenditure.

Transparency of decision-making processes was mentioned as an important success factor by interviewees in all sites.

#### 4.2.5 The public

Public health's relationship with the public also affects priorities and outcomes. One DPH commented that

*To achieve change in need, we need to engage local communities to create a social demand for health.*

A councillor said that it was particularly difficult to get the public to understand why cuts were being made. Efforts were needed to ensure the reasons were clear. It was also felt in one site that the public often did not understand how certain activities could be the responsibility of the council. This view would then be communicated to council members, who would have to feel able to defend a position.

One public health consultant commented that 'what appears in the Daily Mail' can have a significant effect on public opinion. It was suggested that evidence, particularly local evidence, needs to be used to counteract criticism and influence public opinion. Elected members are frequently questioned in surgeries about why particular initiatives are funded.

### 4.3 Historical provision

An interesting example was provided in one site of an activity that would have to be funded even though it was not statutory. Many years ago, the council had set up a binding agreement with a particular sporting club to contribute to its funding in perpetuity. Although the amount of funding was relatively small, it was felt that it was not an ideal way of spending limited funds but could not be avoided.

Where a service has long been provided, and the public is aware and supportive of it, it can be difficult for a local authority to suggest its discontinuation. Public and media pressure can significantly affect the way a council makes its decisions. This can relate not only to services but to the support of iconic local buildings.

One public health consultant suggested that, even three years on, many of the decision-making councillors still tend to consider only the traditionally provided services and are unaware of the changes to requirements that came in with the transfer of public health

responsibilities. Potential ways around this were to provide more sessions, previously successfully carried out, to introduce public health and evidence to councillors.

Even within the same local authority, interviewees' views sometimes differed on the extent of influence of historical service provision. One councillor felt there were no historical priorities because priorities were regularly reassessed.

#### 4.4 Funding issues

One DPH said that the council had initially welcomed the transfer of responsibility for public health, with what it saw as a bag of gold being brought to its door<sup>5</sup>, thinking:

*Your grant looks very enticing!*

However, the council then regarded that money not as a ring-fenced budget but as a pot available for it to spend, an income stream particularly welcome at a time when money was becoming even tighter (public health and councillor agreed on this point). Then, rather than a public health based prioritisation exercise, the authority effectively carried out a 'smash and grab', according to one interviewee, who was concerned that some of the actions were *ultra vires* and designed only to ease the authority's financial difficulties. The situation was worsened when the Chancellor of the Exchequer then announced the budget reductions and eventual disappearance of the ring-fence.

One DPH said that although there were no real tensions between public health and the other council departments,

*there is never enough money ... other departments want as much public health money as they possibly can lay their hands on.*

Tensions over responsibilities for funding are believed to play a significant part in creating or maintaining inter- or intra-organizational relationships. In particular, several interviewees suggested that, within the local authority, anything badged as 'health' is still seen as the responsibility of the NHS or the CCG and some councillors are still asking why the council should have a view on obesity or why it should provide stop smoking services.

Mixed views were expressed about the value of having a ring-fenced budget (including by individuals who could see both advantages and disadvantages). The potential envy of other departments has been mentioned already as a disadvantage. One councillor was not usually in favour of ring-fencing but believed that for public health it was working well, allowing funding of various preventive measures to reduce deprivation and inequalities for which it might otherwise have been difficult to secure council commitment.

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<sup>5</sup> Public health in local authorities is currently funded by a ring-fenced central government grant. This will continue until at least 2018 but public health funding to LAs is being reduced year on year until 2020 (Chancellor's Autumn Statement 2015)

One councillor felt that many of the tensions across different organizations also arose from budget pressures; the example cited was that of the drug and alcohol team, involving the police and the CCG – the councillor said that those involved

*need to sit down and talk about providing the service collectively.*

Disinvestment was said by one councillor to create its own problems. In particular, the different lengths of contract, with varying start and end times, made it difficult to effect changes with appropriate or matching timescales.

One site was deliberately moving to a greater focus on ‘more bang for the buck’, trying to identify actions that had a big impact for relatively little expenditure.

Accountability for the public health budget was felt to be an issue, particularly in one site. There was concern that the statement to PHE saying that the public health budget had been appropriately spent, was signed off by the Chief Executive without necessarily being agreed by the DPH or even seen by the councillor with responsibility for health. One public health consultant felt that there was no real evidence of anything constructive being done by PHE to check on the statement or to challenge its veracity or content. It was suggested by another interviewee that it would be a welcome move if PHE would tighten up its definitions of the mandatory activities so that they were less open to interpretation.

Interviewees at one site talked of the possibility of using an outcome based budgeting approach to try to ensure better monitoring and better investment in priority areas. However various difficulties were recognized, including the issue of additional complication in measuring across unfamiliar programme categories and the possibility that the outcomes currently under discussion were not really outcomes, leading to ‘an outcome based budgeting approach without outcomes’ (a view shared by a public health interviewee and a councillor).

The amount of money available to public health was known to vary and it was suggested by one DPH that where there was felt to be a satisfactory budget, the problems were very different from where public health was really struggling with limited funds. With satisfactory budgets, it was far easier to get approval for spending on the preventive agenda.

It is not only cuts but also the way budgets are arranged or managed that can affect the way public health spending is prioritised. Interviewees at one site felt that there were inconsistencies across the country that allowed budgets to be transferred in different ways in each authority. The way that some specialist NHS service budgets were transferred as well as ‘proper’ public health budgets had caused problems in some areas, where councils (and public health staff) felt it was totally inappropriate for the money to be transferred to the council.

#### 4.5 Data and evidence

Although the public health interviewees at more than one site wanted to make use of a lot of evidence, it was felt that this idea was still alien to some local authorities, where decision-

making across the council had often been based on anecdote and members' opinions. Public health could be seen as challenging these established ways. To ensure proper use of evidence, interviewees at one site said they tended to focus on guidance from national bodies, such as NICE, and also valued some of the PHE advice. One cited example of challenges to evidence-based actions concerned spending on teenage pregnancy and drug users, when some councillors had wondered 'why are you spending on druggies and feckless pregnant girls'.

Although the public health interviewees at one site were concerned that their use of evidence was not always totally accepted by local authorities, the councillor at the same site felt that although they knew the value of the preventive agenda they were sometimes not aware of a strong enough evidence base (and anyway the evidence might be ignored if the activity were not statutory). The same councillor recognized the problem of long-termism in the public health preventive agenda, as did the councillor at one of the other sites.

One public health consultant reported frequently being asked for evidence, although felt that if evidence were put on the scales against a conflicting electoral manifesto or public opinion, it would not weigh as heavy. The level of evidence was also an issue. Whilst the JSNA contained a lot of high level evidence, one councillor, wanting to use the low cost approach of the mile-a-day-run in every school, asked for specific evidence to support this activity.

According to one DPH, priorities supported by several key organizations (such as CCGs, police and crime commissioners, HWBs) were more likely to be accepted by council members (any evidence notwithstanding).

Different types of evidence were felt to have a differential impact on council members. Comparative information (benchmarking) could be very persuasive at one site (according to the DPH), with councillors not necessarily having to show their authority was the best ('as long as we are not the worst...'). In all three sites where formal interviews took place, evidence concerning cost-effectiveness was felt to be very useful but was recognized by several interviewees as often being very difficult to obtain. Financial modelling tools could help, particularly if they allowed a broad picture to be modelled so that councillors could see that if a particular service were cut, this would impact on x, y and z later or elsewhere. An interviewee provided an example – if town centre antisocial behaviour increases, this increases the costs of street cleaning, can force businesses to move out and residents to move out, leaving behind boarded up windows.

#### 4.6 Public health capacity

Lack of public health capacity was felt very keenly in the local authorities. Referring to overall national capacity, one public health consultant said that the NHS had no public health capacity; 'it's all in Public Health England and in local government and there's none in the NHS as it stands'. Other interviewees felt that at local authority level the public health capacity had been very much reduced and split. One public health consultant, commenting

on the differences in immediacy between service provision and some of the preventive actions, said that

*if we don't do a health needs assessment or impact assessment, we will be blamed **at some time**.* (The last three words were emphasised by the interviewee.)

The focus on service provision was felt by one DPH to be unavoidable and was a barrier to preventive work because of the lack of capacity to do both.

## 5 Discussion

As noted earlier, there are limitations as to the generalisability of our findings from the follow-on study; although four sites were initially involved, only three took part in the more formal interviews. Additionally, public health was still in the process of becoming embedded in the local authorities, so that the findings relate to a specific period with many changes underway and more to come. However, interviewees included DsPH, public health consultants and council members with a responsibility for the health portfolio, so that the views of the key players involved in the expenditure of public health budgets were captured.

It is worth stressing the overlap between the issues identified in the follow-on study and the main study. Despite efforts to select sites where prioritisation approaches were (or are) in use, it seems that in none of the sites, both those in the main and those in the follow-on studies, is there much evidence of a sustained commitment to, or of embedding, any such approaches, or adopting them routinely. Perhaps this reflects a failure on our part to select sites in our follow-on study where there was evidence of such practices although we did seek to choose sites where such a commitment did appear to be forthcoming and collected information accordingly to inform our selection. However, this has meant that our chief purpose, namely, to identify ways in which local authorities sought to overcome barriers to using prioritisation processes, has not been fulfilled.

Nevertheless, the lack of continued application of formal techniques is in itself of interest and an important finding since it demonstrates the deep-seated challenges and difficulties confronting local authorities operating in a very complicated context. Site A was the best example of using such an approach to prioritisation though even here the key element was the discussion and the thought processes that went into the scoring. It was unfortunate that Site B was unable to continue with its approach despite a promising start. But a common feature across all the sites between initial contact and the conduct of the interviews was a succession of important developments, including changes of DPH, continuing cuts to budgets, manoeuvring over who should be involved in decision-making, political difficulties and so on. None of these system churn issues could have been foreseen when we made our initial selection of study sites. As a consequence, both the main study and follow-on study have provided more learning about the barriers to using prioritisation processes and support tools than about ways of overcoming them.

### 5.1 Approaches to prioritisation

Only one of the sites was using a matrix approach at the time of the more formal interviews. Another had been using one but had stopped (even though the approach was well regarded) because the budget cuts were so stringent that only a limited number of priorities (mandatory requirements) could be supported, so there was no point trying to identify other potential priorities.

Discussion was the main approach used by the sites, whether or not such discussion was led by use of a matrix. At one site the decision-making was limited to public health at the time of the researcher's first contact, but by the time of the more formal interviews the process

had been amended to allow relevant other professionals to contribute. At another site, discussions had at one time been open to wider participation but had been reduced to allow only the public health department to make the decisions, in order to protect a very rapidly diminishing resource. In spite of this, that site, along with all the others, would prefer to have budgets that were integrated across the whole council.

Even without a formal matrix or formal weighting, the sites tended to consider certain criteria in their deliberations, such as public value, political acceptability, affordability, contribution to the preventive health agenda or to the council's overarching outcomes.

The sites where formal matrices or weighting had been or were being used found the matrices useful as spurs for discussion. Discussion, rather than reliance on or systematic use of decision-support tools, appears to be the most important aspect of the decision-making across all sites.

## 5.2 The influence of politics

The overall council agenda is a huge influence. In one case, only the statutory responsibilities were acceptable as priorities and in all cases public health priorities closely matching council priorities were more likely to be endorsed by the council.

Individual councillors can also be very powerful – as supporters or as opponents. At one site, the leader of the council was said to be the one with the decision-making power, rather than the cabinet. Elsewhere, it was felt that while cabinet had the control, councillors with the health brief could be very persuasive, particularly when they were well acquainted with the public health views and plans. This aligns with the suggestion from more than one interviewee that part of the role of the DPH and the public health department is to promote the ideas of public health, particularly those around prevention, as there is often a need on the part of the council to focus spending on treatment rather than on the preventive agenda. It was also pointed out by several interviewees that most of what a council does is effectively public health but it might sometimes be harder to align major public health priorities directly to council priorities such as improving the economy.

## 5.3 The influence of working relationships

### 5.3.1 Across the council

Three sites, including the one that withdrew from the project, definitely felt that public health had good relationships with the rest of the council. At the other site, discussions revealed that relationships with some departments were successful while relationships with others were less so.

The administrative or managerial location of the public health team affected relationships. For example, if public health came under the adult social services department, it might be more difficult to work on the children's health agenda. Administrative and management



processes could also be problematic, with public health having to get used to new, possibly more formal or more legally accountable, ways of working.

There were felt to be differences in approach between public health and other council departments, not just around processes but in the way they regarded or used evidence (which will be discussed in section 5.6). This could create barriers to successful joint working, as could a lack of understanding of public health that was believed to exist among some councils. Other cultural differences include the way public health uses benchmarking but this does not appear to happen in all of the sites.

Joint or shared priorities were felt to be very useful, leading to public health priorities being accepted (as mentioned above) and enhancing working relationships. System-wide approaches to priority-setting appeared to be desirable.

#### 5.3.2 NHS bodies

Of the three sites where relationships with CCGs were discussed, only one had felt there had been problems (specifically over the integrated care agenda). Generally, CCG/council public health relationships seemed quite good, in part because of CCG/public health relationships developed from the time public health was located in PCTs.

The biggest barrier to good joint working appears to be the fundamental difference in organizations, with direction coming to CCGs from above but councils being directed by elected members (within statutory responsibilities).

#### 5.3.3 Third sector and private sector

Although one council reported a mixed relationship with the third sector, several examples of very good working were mentioned. At least two sites also had good working relationships with the private sector, in connection with specific projects.

#### 5.3.4 Overall joint working

In general, there was recognition in all three sites where formal interviews took place that public health needed the cooperation of statutory, third and private sectors. (The issue was not discussed in the preliminary discussion with the site that withdrew.) Again, many interviewees would like to see a greater system-wide approach to priority-setting and actions.

One of the main barriers was felt to be the uncertainty that accompanies reorganizations, now frequent and often taking a long time, sometimes leading to major changes in service provision and often making it difficult to maintain relationships.

#### 5.3.5 The public

Public views can very much affect the likelihood of public health priorities being accepted. Councillors need to understand the reasons for particular priorities, so they can respond to questions from the public about those reasons and about the reasons for service cuts. Public health teams will often be the ones with the evidence to support the decisions but need to promote their views.

#### 5.4 The influence of historical provision

Historical provision of council services (both services provided prior to transfer and those transferred from NHS) might not only be something the public expects to continue, it might also stem from previous long-term council agreements and be legally impossible to change. As well as the public, some councillors also tend to consider only established courses of action. This is yet another instance of public health having to argue its case persuasively.

#### 5.5 Funding issues

At all four sites, there were concerns that the rest of the council wanted to take away public health funding to use for other council purposes. As mentioned earlier, there was agreement that most council activity *is* public health activity of some sort but often council spending does not necessarily follow the public health categories represented in the ring-fenced budget.

The ring-fenced budget, while generally valued, also led to problems, with other council departments possibly resenting this influx of funding to support what they might see as a small department. Of particular concern was the required statement to PHE, saying that the budget had been appropriately spent. Some interviewees felt that this was often not accurate but that the public health staff and responsible councillor did not always have the opportunity to contribute. With regard to the mandatory activities, interviewees wanted PHE to tighten its definitions so that they were not open to interpretation.

#### 5.6 Issues around data and evidence

As mentioned above, interviewees saw differences in the way public health and other council departments used or accepted evidence. Public health evidence was generally felt to be sound but often not specific enough for councillors interested in certain local priorities. It was also believed that councillors would ignore the evidence if it did not support their own ideas or the views of their constituents.

The most valued evidence appears to be financial or cost-benefit. Such evidence is not always available but it was felt that if councillors could see the wider effects of action or non-action, they would be more likely to support public health recommendations.

Support from other key organizations (such as the police or the CCG or HWB) was felt to add weight to public health proposals. This suggests again that part of the role of the public health department might be to spread the messages of public health across a wide range of organizations.

#### 5.7 Issues around public health capacity

All of the sites said they lacked the capacity to do what they wanted. In particular, there was little capacity to do preventive work, and little expectation that capacity would improve, given the forthcoming further reductions in public health funding.

Even in the current situation, capacity is inadequate. Given that many of the problems mentioned above might be alleviated by public health staff spreading the public health message, increased capacity is essential to allow time for public health awareness-raising.

## Appendix 1: Interview schedule

The lightly shaded text is purely for the interviewer's benefit.

### Interview schedule (follow-on study)

#### *Before starting the interview*

- Introduction to study – overview, aims, purpose of interviews
- Ask the participant if he/she has got any questions and/or would like additional information
- Reassure the participant that we will treat the information confidentially
- Ask permission to record the interview

#### General background of interviewee

- What is your current role?
- Are you involved in decision-making around expenditure on public health?  
(either specific public health budget – depending whether still exists – or on wider public health across the local authority)

#### Priority-setting methods/approaches

*Briefly explain priority-setting approaches – e.g. specific priority-setting tools such as matrices with point-scoring systems; Methods for economic evaluation (e.g. Cost-benefit analysis); Option appraisal; Return on Investment; Programme Budgeting and Marginal Analysis; or multi-agency, multi-disciplinary (or public) consultations*

- How would you describe the approaches taken in this local authority to develop priorities for public health spending or disinvestment?
- Would you say those approaches were productive? - *If not, why not? / If so, why?*

#### Priority-setting in general

*Moving on to more general priority-setting or decision-making, we are keen to explore the factors that make it easier or more difficult to make decisions around public health priorities.*

#### • Organizations/departments/individuals involved

- Who would generally be involved in decision-making around spending on public health? (*specific ph budget or wider public health issues*)
  - To what extent is the CCG involved?
- Are the decisions taken by those people acted upon or do they have to go through processes such as scrutiny?
  - If they have to go through other processes, how likely is it that they will be ratified?
  - Who are the key players in any ratification process? (*Who has the power to veto recommendations?*)
- How influential is the Health and Well-being Board in the decision-making process?
- Do you feel that there is adequate joint working across departments or organizations? (*or is there a lot of silo working across departments*)
- Are there obvious tensions between different organizations/individuals that make decision-making difficult? (*e.g. organizational culture*)
  - If so, are attempts being made to overcome them (and in what way)?
  - If not, were there previously any such tensions that have now been resolved (and if so, how)?
- Where does the greatest power lie to push through or hinder decisions?

- **Agreement on what constitutes public health and the role of the public health team**
  - Is there a reasonable understanding across the decision-makers as to what public health is and what the public health team does? *(possibly including link with council duty of well-being)*
  - Is the public health team involved in strategy development in other directorates such as housing or planning?
  - Does the authority have any plans for strategic investment in public health across different local authority services?
  - Do the decision-makers appear to agree on what is appropriate use of public health money?
    - Can you give examples of what you think might have been inappropriate use?
- **External factors affecting priority-setting decision-making around public health**
  - To what extent are priority-setting decisions affected by:
    - outcomes frameworks (such as public health, NHS or social services)
    - council budget cuts
    - statutory requirements (local authority or public health – *might also refer to requirements that are not very specific about the level of service required*)
    - historical priorities
    - dominance of agenda for integrated care or other local authority areas
    - historical reluctance to disinvest in existing programmes/activities
    - local publicity around specific issues
    - ongoing reorganizations
- **Enablers**
  - How helpful is Public Health England to Local Authorities? *(in terms of priority-setting)*
  - What do you see as the main factors that enable good decision-making around priority-setting?
  - Can you give any examples of success arising because of these factors?
- **Barriers**
  - What do you see as the main barriers to decision-making around priority-setting?
  - Can you give any examples of how such barriers have hindered priority-setting?
- **Any other comments?**
  - Beyond the issues that we have discussed here, do you have any further comments that you wish to add?
  - Are there any comments you would make on the interview and the interview process?

*Ask for relevant documentation.*

*Thank interviewee for participating. Ask if they wish to receive information on the outcomes of the research.*

## Appendix 2: Site A prioritisation, guidance to scoring

1. Public Health Impact - priorities (40 points available)					
Does the intervention directly impact on the Public Health Outcomes Framework indicators?	<b>0 points</b> <b>None</b> Does not impact on any PHOF outcomes <b>OR</b> Not known	<b>10 points</b> <b>Low</b> Addresses one PHOF outcome	<b>20 points</b> <b>Moderate</b> Addresses two PHOF outcomes	<b>30 points</b> <b>High</b> Addresses three PHOF outcomes	<b>40 points</b> <b>Very high</b> Addresses more than three PHOF outcomes
2. Access (20 points available)					
What is the number of residents who are expected to directly benefit from this intervention per year?	<b>2.5 points</b>  <100	<b>5 points</b>  101-500	<b>10 points</b>  501-10,000	<b>15 points</b>  10,001-25,000	<b>20 points</b>  >25,000
3. Vulnerable Communities/Population Groups (40 points available)					
How does this address the direct needs of vulnerable communities/population groups?	<b>0 points</b> <b>No benefits</b>  The proposal is not likely to meet the needs of any vulnerable groups	<b>10 points</b> <b>Low benefits</b>	<b>20 points</b> <b>Moderate benefits</b>  The proposal addresses the needs of vulnerable populations with worse PH outcomes or poorer access but lacks built in systems to capture and measure outcomes	<b>30 points</b> <b>High benefits</b>	<b>40 points</b> <b>Maximum benefits</b>  The proposal demonstrates how it will reduce poor PH outcomes or poorer access to sub-groups of the population and it clearly shows how PH outcomes will be measured and reviewed.


4. Evidence of effectiveness (40 points available)					
What is the strength of evidence of effect of the intervention and its impact?	<b>0 points</b> <b>No evidence</b> There is no evidence available to suggest that the service is effective, but also no evidence that it is harmful	10 points	<b>20 points</b> <b>Limited evidence</b> The service is supported by evidence from published and unpublished studies (grey literature) indicating plausibility and do-ability.	30 points	<b>40 points</b> <b>Good evidence</b> The service is clearly supported by Public Health evidence
5. Efficiency (40 points available)					
Does this intervention provide value for money?	<b>0 points</b> <b>No evidence</b> There is no published evidence of cost-effectiveness of this intervention <b>OR</b> Costs of the service have been benchmarked to similar or existing services and have comparable outputs for higher costs or lower outputs for comparable costs	10 points <b>Limited value for money</b>	<b>20 points</b> <b>Evidence indicates moderate value for money</b> The planned intervention will generate savings which will offset investment either directly (ROI) or indirectly (SROI) <b>OR</b> Costs of the service have been benchmarked to similar or existing services and are comparable for a similar output	30 points	<b>40 points</b> <b>Evidence indicates excellent value for money</b> The intervention is proven to be highly cost-effective with a cost/QALY of <£10k <b>OR</b> The planned intervention will generate significant savings which will offset investment either directly (ROI) or indirectly (SROI) <b>OR</b> Costs of the service have been benchmarked to similar or existing services and are lower for a higher output

6. Acceptability/sustainability (20 points available)					
What would the local impact amongst wider stakeholders or the public be if a reduction or removal of service occurred, e.g. health partners, voluntary sector, etc.	<b>0 points</b> <b>No impact</b>	<b>5 points</b> <b>Minor impact</b>	<b>10 points</b> <b>Moderate impact</b>	<b>15 points</b> <b>High impact</b>	<b>20 points</b> <b>Major impact</b>
	No impact on the public or stakeholders  <b>OR</b> No risk to the viability of provider/s	May have minor impact on the public or stakeholders  <b>OR</b> Minor risk to the viability of provider/s	May have moderate impact on the public or stakeholders  <b>OR</b> Moderate risk to the viability of provider/s	May have a high impact on the public or stakeholders and will necessitate work to demonstrate the reduction/loss of this service  <b>OR</b> High risk to the viability of provider/s	Likely to be unacceptable to the public or partners/stakeholders and will necessitate work to demonstrate the reduction/loss of this service  <b>OR</b> Major risk to the viability of provider/s



### Appendix 3: Site B - explanation of weighting

Criterion	Weight	Explanation of weighting
Narrowing the Gap	30	Narrowing the Gap identified as local priority
Feasibility of Delivery of Medium Term Financial Plan	0	Assumed that all programmes and/or services identified will be able to be delivered within MTFP period, therefore zero weighting
Link to Public Health needs	30	The public health grant conditions provide a mandate for local public health services to meet locally identified needs. The SNA is the principal document where local needs are identified
Links to Frameworks	25	All services and programmes should contribute to the delivery of Public Health Outcomes, which are articulated nationally and locally using the PHOF. Services should also be able to align with the mandated and non-mandated services described in Annex C of Local Government Circular to ensure compliance with the Public Health ring-fenced grant conditions as well as with the PMF.
Evidence Base	15	Services and programmes should be underpinned by a robust evidence base to demonstrate their contribution to public health outcomes. However, there needs to be some consideration of local innovation.



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